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May 2013

DEFENSE HEALTH CARE

Department of Defense Needs a Strategic Approach to Contracting for Health Care Professionals

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May 2013

DEFENSE HEALTH CARE

Department of Defense Needs a Strategic Approach to Contracting for Health Care Professionals

GAO Highlights

Highlights of GAO-13-322, a report to congressional committees

Why GAO Did This Study

DOD operates a large and complex health care system that employs more than 150,000 military, civilian, and contract personnel working in military treatment facilities. Each military department operates its own facilities, and contracts separately for health care professionals to supplement care provided within these facilities. In fiscal year 2011, these contracts totaled $1.14 billion.

In the National Defense Authorization Act for Fiscal Year 2012, Congress mandated that GAO review the military departments' acquisition of health care professional services. This report examines (1) the contracting practices used by the departments and their cost effectiveness; (2) the extent to which the departments consolidate health care staffing requirements; (3) the percentage and associated costs of contract health care professionals working at on-base facilities versus off-base; (4) the training requirements for and experience of medical services contracting personnel; and (5) the extent to which the departments' policies address legislated quality standards for contract civilian health care professionals and for staffing companies that provide these professionals. To conduct this review, GAO reviewed military health care policies, analyzed DOD's fiscal year 2011 procurement and staffing data, and interviewed DOD military health system officials.

What GAO Recommends

GAO recommends that the Secretary of Defense develop a DOD-wide strategic approach to contracting for health care professionals. DOD concurred with the recommendation.

View GAO-13-322. For more information, contact William T. Woods at (202) 512-4841 or WoodsW@gao.gov.

What GAO Found

The military departments—the Army, Navy, and Air Force—generally use competition and fixed-price contracts when contracting for medical professionals. These practices can provide lower prices or reduced risk for the government. The military departments use a number of contract arrangements, including contracts awarded to multiple health care staffing companies, for health care professionals. Military department analyses indicate that multiple-award contracts result in lower prices compared to other contract arrangements.

The Department of Defense (DOD) does not have a consolidated agency-wide acquisition strategy for medical services. In the absence of such a strategy, contracting for health care professionals is largely fragmented. For example, the military departments had not consolidated their staffing requirements by developing joint contracts beyond a limited number of instances amounting to about 8 percent of the fiscal year 2011 spending on health care professionals. The departments have made efforts to use multiple-award contracts to consolidate intraservice staffing requirements, but GAO identified several instances where multiple task orders were placed for the same type of provider in the same area or facility. A more consolidated strategic sourcing strategy could allow DOD to acquire medical services in a more cost-effective way.

Nearly all of the military departments' 11,253 contract health care professionals—96 percent—worked in 114 on-base military treatment facilities in fiscal year 2011, while the remaining 4 percent worked in 8 off-base clinics. The costs associated with the contracted health care services provided at on-base facilities are not comparable to such costs at off-base facilities for a variety of reasons. For example, some Military Health System cost accounting data have been characterized as unreliable. In addition, according to DOD officials, labor categories, labor costs, and full time equivalent calculations all vary by military department and in some cases by facility, contract, or geographic location, making a cost comparison problematic.

DOD medical services contracting personnel are subject to DOD-wide training requirements. Consistent with DOD-wide training for all its contracting officers, DOD does not require health care contracting officers to have specialized training or experience. The required training provides a foundation for career field knowledge and is not targeted to specific types of acquisitions, including contracts for health care professionals. Health care experience among contracting personnel varied by location. Air Force contracting officers are not typically dedicated to medical services contracting, unlike their counterparts in the Army and Navy. The military departments provide contracting officers' representatives, who provide contract oversight, with specialized training in contracting for health care.

GAO found that each of the departments has policies or procedures in place that generally address most of the legislated quality standards enacted in 2007 for contract health care professionals and the staffing companies that provide them. However, DOD did not require the military departments to use consistent quality standards in response to this legislation because DOD officials believed that the departments were already applying these standards as part of their contracting processes.

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Abbreviations

BRAC	Base Realignment and Closure
COR	contracting officer's representative
CSA	clinical support agreement
DAU	Defense Acquisition University
DAWIA	Defense Acquisition Workforce Improvement Act
DOD	Department of Defense
FAR	Federal Acquisition Regulation
FPDS-NG	Federal Procurement Data System-Next Generation
FTE	full-time equivalent
ISA	individual set-aside
JTF CapMed	Joint Task Force National Capital Region Medical
MTF	military treatment facility
NDAA for FY 2007	National Defense Authorization Act for Fiscal Year 2007
NDAA for FY 2012	National Defense Authorization Act for Fiscal Year 2012
TMA	TRICARE Management Activity
VA	Department of Veterans Affairs

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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May 28, 2013

The Honorable Carl Levin
Chairman
The Honorable James M. Inhofe
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Howard P. "Buck" McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

The Department of Defense (DOD) operates a large and complex health care system that employs more than 150,000 military, civilian, and contract personnel working in military hospitals and clinics, commonly referred to as military treatment facilities (MTF). DOD's fiscal year 2014 budget request for health care is almost $50 billion, and is projected to increase substantially in the next few years. Historical rates of cost growth in DOD's Military Health System have been significantly higher than the corresponding rates in the national economy. Within DOD, each of the military departments—Army, Navy, and Air Force—operates its own MTFs, and generally contracts separately for health care professionals to supplement care provided within these facilities. As health care consumes an increasingly large portion of the defense budget, DOD leadership has recognized the need to reduce duplication and overhead, and operate the most efficient health system possible. In addition, DOD must balance the challenges posed by maintaining a health care system that meets the military's readiness needs while also making changes in its business and health care practices to control costs and improve effectiveness.

Section 726 of the National Defense Authorization Act for Fiscal Year 2012 (NDAA for FY 2012) directed us to review the contracting activities of the military departments with respect to providing health care professional services to members of the armed forces, dependents, and

retirees.[1] This report (1) describes the contracting practices used by the military departments to provide health care professional services and what is known about the cost effectiveness of these practices, (2) assesses the extent to which the military departments have consolidated their health care staffing requirements, (3) identifies the percentage of contract health care professionals at on-base and off-base facilities and discusses the extent to which the costs associated with care provided by these professionals can be compared, (4) describes the training requirements and experience of medical services contracting personnel, and (5) identifies the extent to which the military departments have policies or procedures that address legislated quality standards for contract health care professionals and for the staffing companies that provide them.

To address contracting practices, we analyzed data obtained from the Federal Procurement Data System-Next Generation (FPDS-NG) on medical services contracts funded in fiscal year 2011, the latest year for which complete data were available when we began our review.[2] We analyzed DOD's contract spending for medical services based on three different factors– whether the contracts were awarded competitively, the pricing terms, and the contract arrangement. We also reviewed past reports by DOD, GAO, and others. To assess the consolidation of health care staffing requirements, we obtained data from the military departments on the number and dollar value of contracts for health care professionals.[3] To determine on-base and off-base percentages of health care professionals, we obtained and reviewed data from the military departments on the type, number of, and obligations associated with contract health care professionals at all on-base MTFs and associated off-base clinics in fiscal year 2011, the latest year for which complete data were available when we began our audit work. We also discussed with knowledgeable officials the relevant data DOD maintains on costs associated with on-base and off-base facilities and potential cost

[1]Pub. L. No. 112-81, § 726 (2011), as amended by Pub. L. No. 112-239, § 733.

[2]FPDS-NG, the primary government-wide contracting database, provides information on government contracting actions, procurement trends, and achievement of socioeconomic goals, such as small business participation.

[3]We obtained data from the Army, Navy, Air Force, and the Joint Task Force National Capital Region Medical Command (JTF CapMed). JTF CapMed manages MTFs within the National Capital Region.

comparison approaches and associated limitations. To describe contract training requirements and experience, we reviewed DOD-wide and military department-specific policies and requirements for contracting personnel. We also obtained information on the training and experience of contracting personnel at facilities with small and large numbers of contract health care professionals. To address quality standards, we reviewed federal regulations, DOD and military department-level policies and procedures, and standard contract provisions, as provided by the military departments. We reviewed this documentation to assess whether each of the military departments generally addressed specific legislated quality standards outlined in section 732 of the National Defense Authorization Act for Fiscal Year 2007 (NDAA for FY 2007).[4]

To address all objectives, we interviewed and obtained documentation, including contract data, from officials at 11 MTFs[5] and the following organizations:

- Army Health Care Acquisition Activity,
- Navy Medical Logistics Command,
- Air Force Medical Service,
- Joint Task Force National Capital Region Medical Command (JTF CapMed), and
- DOD's TRICARE Management Activity (TMA).

We assessed the reliability of these data by interviewing officials from the military departments and testing the data for any obvious errors. We determined that the data were sufficiently reliable for the purposes of our review. See appendix I for additional details on our scope and methodology.

We conducted this performance audit from July 2012 to May 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[4]Pub. L. No. 109-364 (2006).

[5]See appendix I for a list of the 11 MTFs and our method for selecting them.

Background

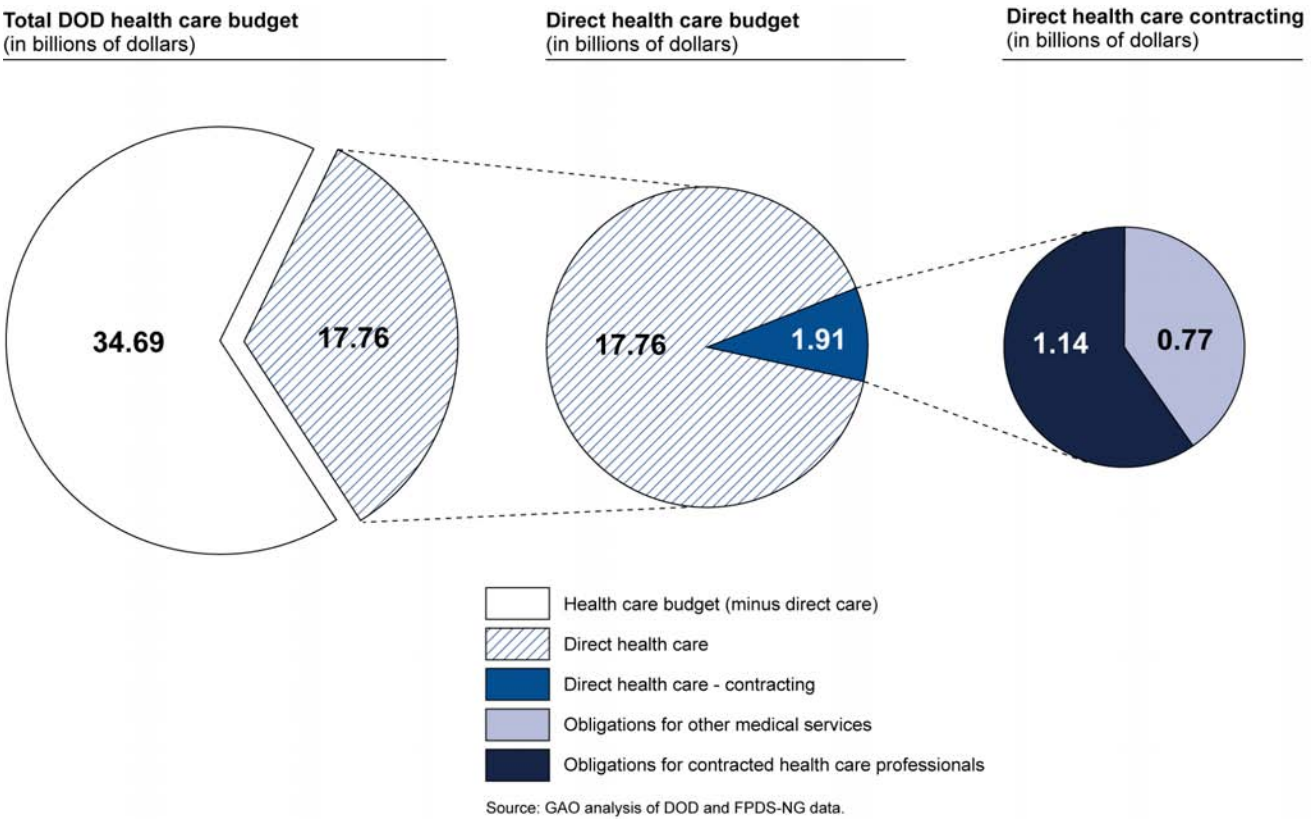
DOD's Military Health System

DOD's Military Health System has two missions: supporting wartime and other deployments, and providing peacetime health care. In fiscal year 2011, DOD offered health care services to about 9.7 million eligible beneficiaries in the United States and abroad through TRICARE, the Military Health System's regionally structured health care program.[6] Under TRICARE, beneficiaries may obtain care either through DOD's direct care system of MTFs, or through DOD's purchased care system of civilian providers.[7] The total DOD health care budget for fiscal year 2011 was $52.45 billion, of which $17.76 billion was to provide health care through the direct care system of MTFs. Of the $17.76 billion in direct care costs, DOD spent about $1.91 billion contracting for various medical services, including about $1.14 billion for contract health care professionals, the primary focus of this report. Figure 1 below shows the total DOD health care budget, the amount spent on direct health care, and the amount the military departments spent on contracts for health care professionals working in MTFs in the United States in fiscal year 2011.

[6]Eligible beneficiaries include active duty personnel and their dependents, medically eligible National Guard and Reserve service members and their dependents, and retirees and their dependents and survivors.

[7]Through individual agreements between MTFs and the Department of Veterans Affairs' (VA) medical centers, eligible beneficiaries may also receive certain types of care from VA medical centers in some locations.

Figure 1: DOD Health Care Budget and Amounts Spent on Contracted Medical Services in Fiscal Year 2011



Source: GAO analysis of DOD and FPDS-NG data.

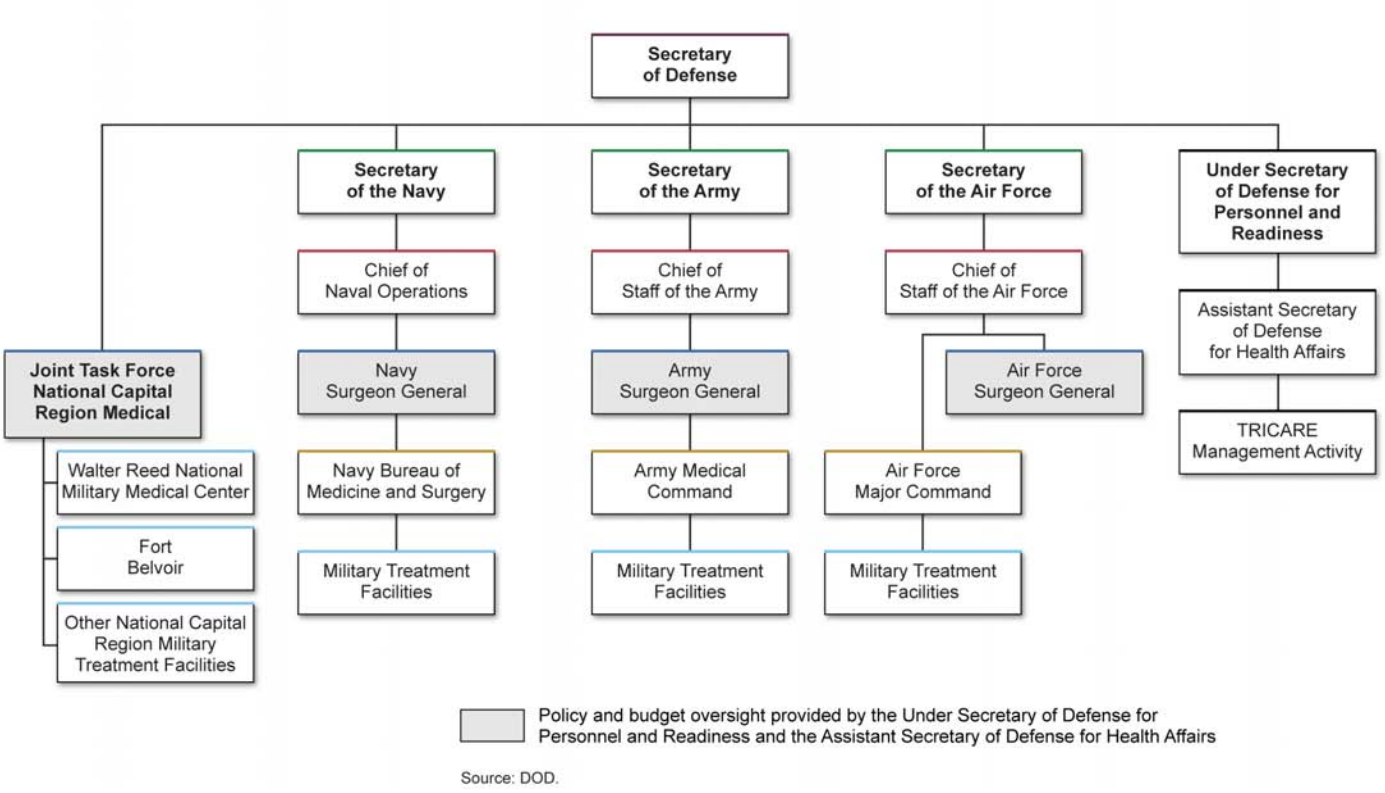
Notes: Obligations for other medical services includes, but are not limited to, contract health care professionals outside of the United States, and research and development-related services.

Obligations for contract healthcare professionals excludes contract health care professionals working in military treatment facilities outside the United States, contracts for research and development, dental and veterinary professionals, as well as administrative, janitorial, food, or housekeeping services.

The Assistant Secretary of Defense for Health Affairs (Health Affairs) is the principal advisor for all DOD health policies and programs. This office issues policies, procedures, and standards that govern the management of DOD medical programs and has the authority to issue DOD instructions, publications, and memorandums that implement policy approved by the Secretary of Defense or the Under Secretary of Defense for Personnel and Readiness. However, this office does not have direct command and control of the military departments' MTFs. TMA, under the authority and direction of Health Affairs, is responsible for awarding, administering, and managing DOD's contracts for purchased care,

including the regional managed care support contracts. See figure 2 for the current organizational structure of DOD's Military Health System.

Figure 2: Governance Structure of the Military Health System As of April 2012



Source: DOD.

Under the direct care system, each military department recruits, trains, and funds its own medical personnel to administer medical programs and provide medical services to beneficiaries. The Departments of the Army and the Navy each has a medical command, headed by a surgeon general, who manages each department's MTFs and other activities through a regional command structure. Within these medical commands, the Army and Navy have separate but similarly centralized approaches to contracting for medical services, including health care professionals. The Army acquires medical services through the Health Care Acquisition Activity, which has a main contracting center and five regional contracting offices. The Naval Medical Logistics Command is in charge of providing contracting support for medical services for both the Navy and the Marine Corps. Though similar in his role as medical advisor to the Air Force Chief of Staff, the Air Force Surgeon General exercises no command authority

over Air Force MTFs. The Air Force does not have a medical contracting command like the other two services. Instead, the Air Force has a decentralized contracting structure and relies on more than 60 separate local base contracting offices to acquire medical services.[8]

An additional medical organizational structure—JTF CapMed—was established in 2007 to manage MTFs within the National Capital Region and to execute actions required under the Base Realignment and Closure (BRAC) process.[9] JTF CapMed is responsible for the management of the Walter Reed National Military Medical Center in Bethesda, Maryland, which was created by combining Walter Reed Army Medical Center and the National Naval Medical Center; and Ft. Belvoir Community Hospital, which replaced DeWitt Army Community Hospital at Ft. Belvoir, Virginia. JTF CapMed relies on the Army to award contracts for health care professionals because it does not have its own contracting authority.

Figure 3 depicts the size and location of MTFs in the United States.

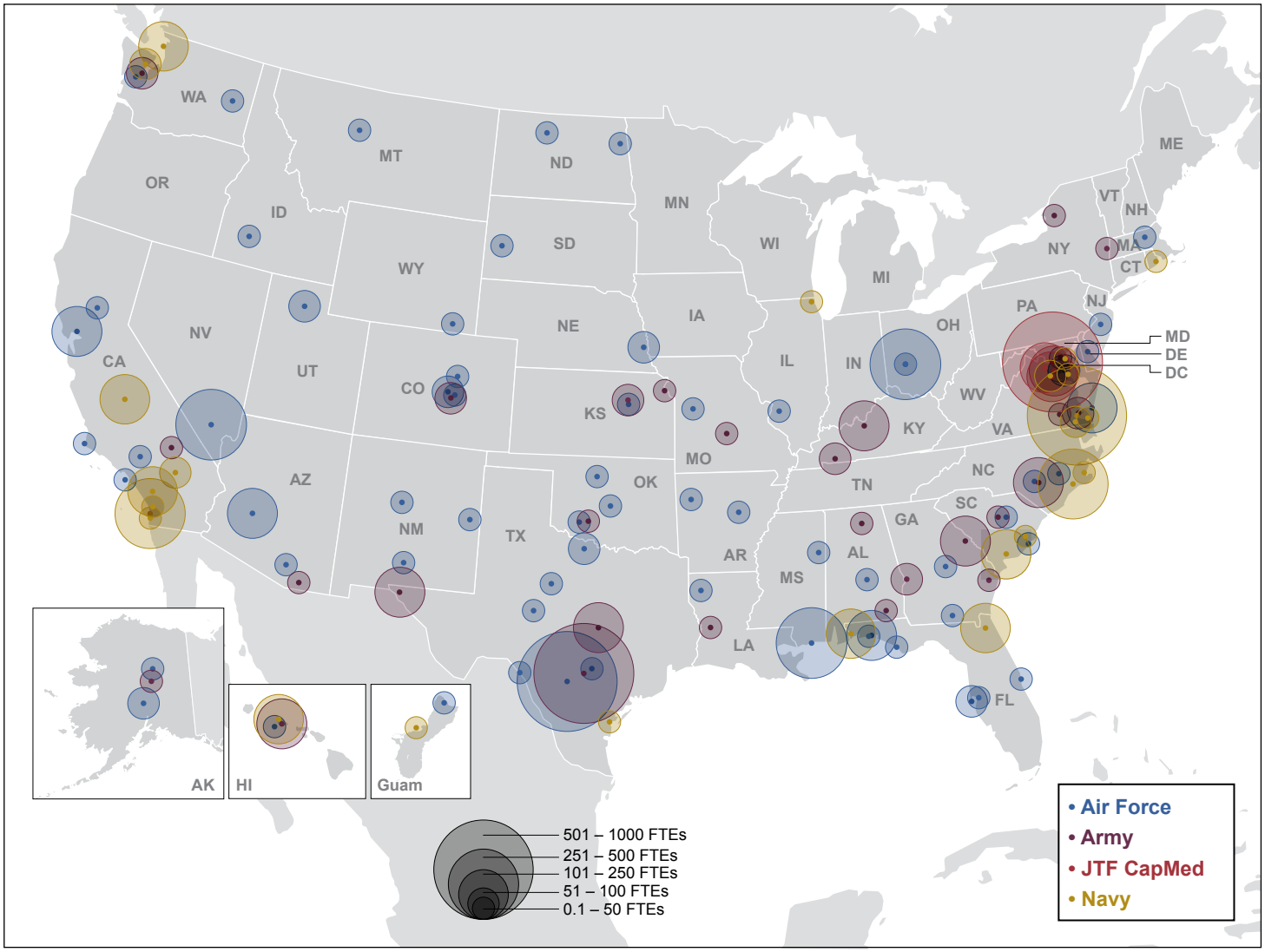
[8]In addition, the Air Force Medical Support Agency provides support and acquisition planning for some medical services and the Air Force Medical Operations Agency provides for policy and guidance on purchasing medical services.

[9]BRAC is a process that the Department of Defense used to determine which military bases could be closed or realigned.

Figure 3: Location of On-base Military Treatment Facilities (MTF) and the number of Full-time Equivalents (FTE) at Each Location

Interactive Graphic

Roll your mouse over the colored text in the legend to see the data by service. For the print version, see appendix II. For the full data set, see appendix III.



Source: GAO analysis of DOD data; Map Resources (map).

[a]Certain low-dollar, fixed-price contracts are closed using a more simplified process.

Contracting Mechanisms for DOD Medical Services

A variety of contracting arrangements are available to DOD to contract for health care professionals. These contracting arrangements are subject to the Federal Acquisition Regulation (FAR)—the primary regulation for use by all federal executive agencies in their acquisition of goods and services. Table 1 lists some of the different contracting arrangements used to contract for health care professionals, including multiple-award contracts.[10]

Table 1: Selected Medical Services Contracting Arrangements

Contract arrangement	Description
Multiple-award contracts	• Indefinite-delivery, indefinite-quantity contracts are awarded to multiple health care staffing companies who recruit and assign providers to fill positions required under specific task orders. • Health care staffing companies compete to be awarded these contracts. • Individual task orders are then competed amongst the staffing companies with the underlying contract. Staffing companies then recruit health care professionals. • Each staffing company that is awarded a contract is guaranteed a minimum level of orders.
Individual set-aside (ISA) contracts	• An ISA is a contract directly with an individual health care professional.
Clinical support agreements (CSA)	• CSAs are used to acquire health care professional services via non-competitive modifications of one of three regional TRICARE managed care contracts. • CSAs are typically used to contract for health care professionals in hard to fill or scarce specialties, especially in geographically remote locations.
General Services Administration schedule contracts	• The General Services Administration's federal supply schedule program provides the government with a simplified process for acquiring goods and services through schedule contracts for medical products and services, including those of health care professionals.

Source: GAO analysis.

Notes: These arrangements are not the only contracting arrangements that are used to acquire medical services. Not all military departments use all contracting arrangements. For example, the Navy no longer uses CSAs.

The military departments contract for many different types of health care professionals. For example, they often contract for nurses, family practice doctors, and medical assistants, among others.

[10]For the purposes of this report, we are referring to multiple-award indefinite-delivery, indefinite-quantity contracts as "multiple-award contracts." An indefinite-delivery, indefinite-quantity contract provides for an indefinite quantity, within stated limits, of supplies or services during a fixed period. The government places orders for individual requirements. These contracts fall under FAR Subpart 16.5. A task order is an order for services placed against an existing contract or with government sources.

The typical process for contracting for these types of professionals is as follows:

- Once it has been determined that a staffing requirement needs to be fulfilled through a contractual agreement, the acquisition strategy is developed. The strategy addresses the type of contracting arrangement that should be used, the payment terms to use, and the competition requirements.
- A contracting officer—who is a federal employee with the authority to enter into, administer, and/or terminate contracts—awards a contract.
- A contracting officer's representative (COR) is assigned to oversee the contract and ensure that the contractor is performing in accordance with the standards and terms that are set forth in the contract. If problems with a contractor's performance arise, the COR serves as the contract focal point between the contracting officer and contractor.

DOD Generally Uses Competition, Fixed Prices, and Multiple-Award Contracts When Acquiring Medical Services

All three military departments used competition and fixed-price contracts for a majority of their medical services contract obligations in fiscal year 2011. Together, the three military departments most often use multiple-award contracts to contract for health care professionals. Military department analyses indicate that multiple-award contracts may result in lower costs compared to some other contract arrangements. In addition, the military departments use other contract arrangements, such as clinical support agreements (CSA) to fill requirements in a remote location or for a particular health care specialist.

The Military Departments Use Competitively Awarded Fixed-Price Contracts for Medical Services

The military departments obligated $1.91 billion for medical services in fiscal year 2011.This figure includes $1.14 billion for contract health care professionals as well as other medical services contract obligations within and outside of MTFs worldwide.[11] Of the $1.91 billion, the military departments used competition for approximately 75 percent of obligations when contracting for medical services. Federal regulations generally require the use of full and open competition, which can help to reduce costs. We have previously reported that competition is a critical tool for achieving the best value.[12] Table 2 shows the percentage of each military department's direct health care medical services obligations that were competed in fiscal year 2011.

Table 2: Obligations and Percentage of Obligations for Competed Contracts for Direct Health Care Medical Services, Fiscal Year 2011

Military department	Competed obligations	Non-competed obligations	Total obligations	Percent of obligations competed
Army	$559,791,729	$304,042,033	$863,833,763	65
Navy	470,968,341	99,896,800	570,865,141	83
Air Force	408,732,623	63,184,732	471,917,355	87
Total	**$1,439,492,694**	**$467,123,564**	**$1,906,616,258**	**75**

Source: GAO analysis of FPDS-NG data.

Note: Numbers may not add due to rounding.

We also found that fixed-price contracts were used for more than 90 percent of direct health care medical service obligations in fiscal year 2011, as shown in table 3. Generally, under a fixed-price contract for services, the government pays a certain amount for the services

[11]An obligation is an action that legally binds the federal government to a future expenditure. The $1.91 billion figure includes all medical service contract obligations reported in FPDS-NG for the Army, Navy, and Air Force for fiscal year 2011. Obligations for medical services other than those specifically for contracted health care professionals in U.S. MTFs are included in this figure, such as laboratory testing. Medical services obligations from all other DOD agencies accounted for less than one percent of the total for this type of obligation and are not included in the $1.91 billion. See table 4 for additional data, including obligations for contract health care professionals by service.

[12]GAO, *Defense Contracting: Competition for Services and Recent Initiatives to Increase Competitive Procurements,* GAO-12-384 (Washington D.C.: Mar. 15, 2012).

specified.[13] We previously have reported that this type of contract generally results in the least amount of risk to the government.

Table 3: Obligations and Percentage of Obligations for Fixed-Price and Non-Fixed-Price Contracts for Direct Care Medical Services, Fiscal Year 2011

Military department	Fixed-price obligations	Obligations other than fixed-price	Total obligations	Percent of obligations that were fixed-price
Army	$800,708,019	$63,125,744	$863,833,763	93
Navy	567,461,522	3,403,619	570,865,141	99
Air Force	431,027,236	40,890,119	471,917,355	91
Total	**$1,799,196,777**	**$107,419,481**	**$1,906,616,258**	**94**

Source: GAO analysis of FPDS-NG data

Note: Numbers may not add due to rounding.

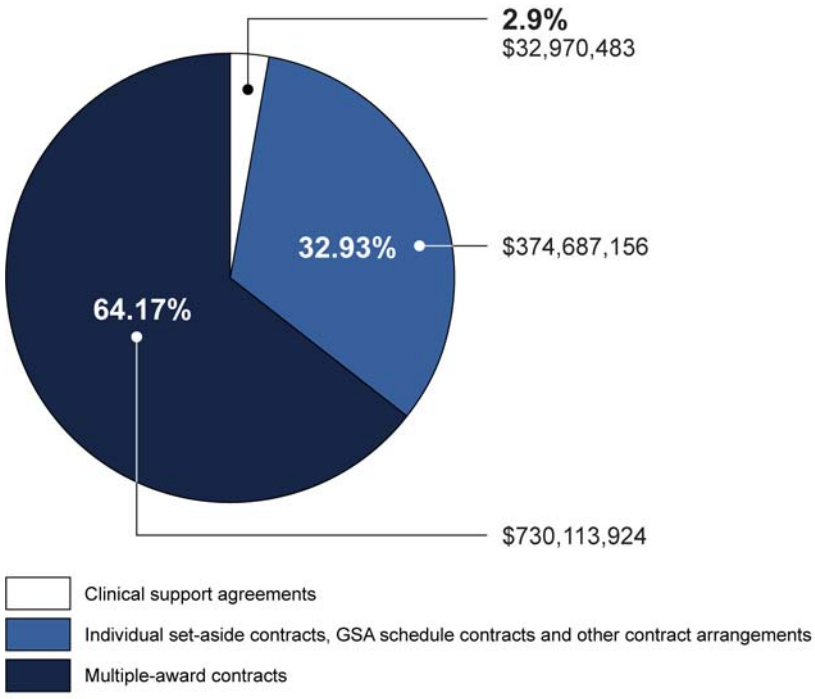
Military Departments Use Multiple-Award Contracts for Various Reasons, Including Perceived Cost Effectiveness

We found that the Army, Navy, Air Force, and JTF CapMed together used multiple-award contracts for 64 percent of the $1.14 billion in obligations for contracts for health care professionals in fiscal year 2011.[14] CSAs accounted for only 3 percent of the obligations spent on health care professionals in the same time period. Figure 4 shows the percentage of fiscal year 2011 obligations for health care professionals by contract arrangement.

[13]Some fixed-price contracts provide for an adjustable price. Fixed-price contracts providing for an adjustable price may include a ceiling price, a target price (including target cost), or both. Fixed-price contracts generally place upon the contractor risk and full responsibility for all costs and resulting profit or loss, and thus provide incentive for the contractor to control costs. A cost-reimbursable contract provides for a payment of allowable incurred costs to the extent prescribed in the contract. These contracts establish an estimate of total cost for the purpose of obligating funds and establishing a ceiling. Contractors can go above this ceiling price at their own risk or with permission of the contracting officer. A cost-reimbursable contract is often used for research and development services.

[14]Army multiple-award contracts account for 81 percent of their obligations, Navy multiple-award contracts account for 79 percent of their obligations, Air Force multiple-award contracts account for 49 percent of their obligations, and JTF CapMed multiple-award contracts account for 42 percent of their obligations in fiscal year 2011.

Figure 4: DOD's Fiscal Year 2011 Obligations for Health Care Professionals by Contract Arrangement



Source: GAO analysis of DOD data.

Because multiple-award contracts are competitive, they avail the military departments of one of the most fundamental and cost effective tools in contracting. Competition is the cornerstone of a sound acquisition process and a critical tool for achieving the best return on investment for taxpayers. Officials from the military departments told us that they use multiple-award contracts for many reasons. In addition to perceived cost effectiveness, officials stated that multiple-award contracts result in shorter acquisition lead times and reduce the risk of bid protests.[15] Officials also stated they use multiple-award contracts because these contracts are awarded to small businesses, which helps the military departments meet their small business contracting goals. In fact, 100 percent of the current Army, Navy, and Air Force multiple-award contracts

[15]In general, a bid protest is a challenge to the award or proposed award of a contract for procurement of goods and services or a challenge to the terms of a solicitation for such a contract.

are awarded to small businesses. DOD officials also stated that multiple-award contracts have facilitated the streamlining of acquisitions and the standardization of contract requirements, which saves time and contract administration costs.

During our review, Navy and Air Force officials completed analyses of their contracting arrangements which indicated that multiple-award contracts may result in lower costs when contracting for health care professionals compared to CSAs.[16] Specifically, Navy officials conducted an analysis comparing the hourly costs associated with the same type of health care professional for each of three different contract arrangements—multiple-award contracts, individual set-aside (ISA) contracts, and CSAs. Based on this analysis, the Navy determined that the hourly rate of providers contracted via CSAs was higher than under multiple-award contracts for the same types of services. Similarly, Air Force officials told us and provided analysis indicating that CSAs cost more than multiple-award contracts. In addition, the Air Force conducted a separate analysis to determine cost savings on their multiple-award contracts. Based on this analysis, an Air Force official stated that they have realized $13.8 million, or 15 percent, in savings on their current multiple-award contracts—which took effect in December 2011—compared to their previous multiple-award contracts.[17]

The Military Departments Also Use Other Contracting Arrangements in Contracting for Services for Health Care Professionals

Each military department has the flexibility to employ a variety of other contract arrangements to meet its needs for health care professionals. For example, Navy officials stated they sometimes contract directly with an individual health care professional using an ISA when an individual's qualifications will be used as the primary selection criterion and cost of the contract is not as important as the provider's qualifications. Navy officials stated they also use ISAs because they are more likely to be able to pay a health care specialist a competitive market-based salary if they contract with the provider directly instead of contracting with a staffing company that typically adds 15-20 percent in overhead costs. A DOD

[16]The Army indicated that because TMA is responsible for CSAs, they no longer had the visibility into the costs of the CSAs in order to perform an analysis.

[17]While the Navy and the Air Force provided us the results of these analyses, we did not independently assess the methods they used to conduct them. However, we discussed the data sources and the limitations of these studies with officials from each military department.

Inspector General report stated that ISAs may be appropriate in certain circumstances, such as acquiring a scarce specialty. One drawback of using an ISA is the amount of time it takes to award a contract. According to Navy officials, it can take 9-12 months for a contract to be awarded. If the health care professional on the contract decides to leave, the military departments are left with an unfulfilled requirement while a new contract is developed, solicited, and awarded.

A CSA is another contracting arrangement that can be used to acquire health care professionals. Similar to ISAs, CSAs are often used to contract for hard-to-fill positions for health care specialists, especially in remote locations. Although the Navy used CSAs in the past to fill requirements for health care professionals, Navy officials stated that they currently do not use CSAs because this contract arrangement is less cost effective and provides for less competition. Although CSAs were reported by the military departments to be more expensive than multiple-award contracts, TMA officials stated that they have been used to fill positions when other contracting arrangements have been unsuccessful.

Regardless of the contract arrangement, some DOD officials told us that it is challenging to fill the requirements for many of the highly skilled health care professionals they need to work at MTFs. For instance, in 2012, multiple-award contracts were competitively awarded to staffing companies specifically for the National Capital Region. Some of the task orders on these multiple-award contracts had to be terminated when the staffing companies could not recruit incumbent health care professionals whose previous salaries had been well above prevailing market rates. This resulted in insufficient time for them to recruit new employees and complete the hiring process without causing gaps in service. Air Force officials also experienced similar challenges in their implementation of multiple-award contracts. For example, some of their multiple-award task orders were terminated because the staffing companies were unable to fill the requirements based on the contracted prices they had proposed.

Consolidation of Staffing Requirements Is Limited in the Absence of a DOD-wide Acquisition Strategy

Contracting for health care staffing requirements across the military departments remains largely fragmented. In the absence of an agency-wide strategy, the military departments have attempted to consolidate some staffing requirements, but these efforts have been limited. Over the last 9 years, various DOD groups as well as GAO have recommended that DOD take steps toward such a strategy, but DOD still does not have an agency-wide acquisition strategy to consolidate these requirements.

Despite Previous Recommendations, DOD Does Not Yet Have a Strategic Approach to Acquiring Medical Services

Studies and reports by GAO and others have identified challenges with the fragmented approach that the military departments take to contract for medical services. For example, in 2004, a DOD Inspector General report found that the Military Health System could better coordinate contracting efforts and reduce duplication and fragmentation among DOD contracting organizations that acquire medical services.[18] The report called for a joint and strategic enterprise approach to medical services acquisition.

In 2005, a DOD-wide council convened by the Assistant Secretary of Defense for Health Affairs recommended that DOD identify an alternative to the existing approach for acquiring direct care medical services, and suggested the need for a joint process and joint contracting centers responsible for the coordination, development, and contract execution of medical services acquisitions.[19] This council also recommended that DOD establish strategic sourcing councils to develop strategies for sourcing key labor categories, including nurses and radiologists, and collect standardized aggregate procurement data across military departments.[20] Strategic sourcing involves a shift away from numerous individual procurements to a broader aggregate approach, and often results in cost savings. Our prior work found that success in this regard requires the commitment of senior management, as well as reliable and detailed

[18]DOD Inspector General, *Acquisition: Direct Care Medical Services Contracts*, D-2004-094 (Arlington, Va.: June 24, 2004).

[19]DOD Office of the Under Secretary of Defense for Acquisition, Technology and Logistics, *Report to the Office of Management and Budget: Implementation of Strategic Sourcing Initiatives Fiscal Year 2006 Update* (March 2007).

[20]The 2006 Quadrennial Defense Review Roadmap for Medical Transformation also incorporated some of the recommendations of the council.

agency-wide spending data to identify opportunities to leverage buying power, reduce costs, and better manage suppliers.[21]

In 2007, DOD drafted a charter for a Defense Medical Strategic Sourcing Council. The council's charter stated that its goals were to allow DOD to standardize the professional services acquisition process, further decrease variation in unit cost for services, and reduce acquisition workload. However, according to a TMA official, the military departments never signed the charter, and the council was never convened.

GAO reported in July 2010 that DOD would benefit from enhanced collaboration among the military departments in their processes for determining professional medical services requirements and recommended that DOD identify, develop, and implement joint medical personnel standards for shared services.[22] While DOD concurred with our recommendation, as of March 2013, no action has been taken to address it. In our March 2011 report on opportunities to reduce duplication, overlap, and fragmentation in government programs, we noted that consolidating common administrative, management and clinical functions within the Military Health System could increase efficiencies and significantly reduce costs, but that DOD had taken only limited actions in this area.[23]

[21]We also found that the federal government is not fully leveraging its buying power to obtain the most advantageous terms and conditions for its procurements. We noted that DOD spent only 6 percent, or $19 billion, through strategic sourcing contracts for all acquisitions in 2011. However, DOD was unable to provide a comprehensive list of agency-wide strategic sourcing initiatives. GAO, *Strategic Sourcing: Improved and Expanded Use Could Save Billions in Annual Procurement Costs*, GAO-12-919 (Washington, D.C.: Sept. 20, 2012).

[22]GAO, *Military Personnel: Enhanced Collaboration and Process Improvements Needed for Determining Military Treatment Facility Medical Personnel Requirements*, GAO-10-696 (Washington, D.C.: July 29, 2010).

[23]In March 2011, GAO issued its first annual report to the Congress on potential duplication, overlap, and fragmentation in the federal government. The report also identified opportunities to achieve cost savings and enhance revenues. We identified 81 areas—which span a wide range of government missions—with a total of 176 actions that the Congress and the executive branch could take to reduce or eliminate unnecessary duplication, overlap, and fragmentation or achieve other potential financial benefits. See GAO, *Opportunities to Reduce Potential Duplication in Government Programs, Save Tax Dollars, and Enhance Revenue*, GAO-11-318SP (Washington D.C.: Mar. 1, 2011).

In June 2011, the Deputy Secretary of Defense established a Task Force to review various options for changes to the overall governance structure of the Military Health System and of its multi-service medical markets.[24] The Task Force identified 13 potential governance options for the Military Health System. DOD selected an option for Military Health System governance that would create a defense health agency in part to assume the responsibility for creating and managing shared services, and leave the military chain of command intact with the military departments in control of their military treatment facilities. This option would include a shared services concept to consolidate common services, including acquisition, under the control of a single entity.[25] The Deputy Secretary of Defense stated in a March 2012 memo that DOD recognizes that there are opportunities to achieve savings in the Military Health System through the consolidation and standardization of many shared services, including but not limited to pharmacy programs, medical education and training, health information technology, budget and resource management, and acquisitions.[26]

While DOD is moving forward incrementally with its plans to transform the Military Health System structure and set up the defense health agency, decisions about the consolidation of health care staffing requirements remain outstanding. For example, DOD established a medical services contracting subworking group in 2012. According to DOD officials, the group is in the process of examining issues related to medical services acquisition and anticipates briefing out its recommended courses of action within DOD in the July 2013 time frame. Its potential recommendations include three different approaches to realigning and potentially consolidating the responsibility for medical services

[24]Multi-service medical markets are service areas in which more than one military department provides military health care services.

[25]However, as we reported previously, DOD did not develop a business case analysis that would provide a data-informed rationale for implementing the concept. GAO, *Defense Health Care: Additional Analysis of Costs and Benefits of Potential Governance Structures Is Needed*, GAO-12-911 (Washington D.C.: Sept. 26, 2012).

[26]Deputy Secretary of Defense Memorandum, Planning for Reform of the Governance of the Military Health System (Mar. 2, 2012).

acquisitions within DOD.[27] Additionally, in the National Defense Authorization Act for Fiscal Year 2013, Congress included a requirement for DOD to provide an implementation plan for its governance reforms, including goals, timeframes, and estimated savings, among other things.[28]

In the Absence of a DOD-wide Strategy, Consolidation of Staffing Requirements Has Been Limited

In the absence of an agency-wide approach for medical services acquisition, there have been only limited instances of the consolidation of health care staffing requirements. Some of these instances have involved efforts across the military departments. For example, the joint contracts that were reported to us accounted for approximately 8 percent of the $1.14 billion in obligations for health care professionals in fiscal year 2011. Other efforts have involved actions within the departments. For example, the departments have made efforts to use multiple-award contracts to consolidate intraservice staffing requirements, but we identified several instances where multiple task orders were placed for the same type of provider in the same area or facility.

Interservice Consolidation

The military departments have consolidated a limited number of staffing requirements by developing contracts used at joint facilities such as those in San Antonio and the National Capital Region. All told, the joint contracts that were reported to us make up approximately 8 percent of the $1.14 billion in obligations for health care professionals in fiscal year 2011. In 2009, the Army established two contracts for nurses to work at the San Antonio Military Medical Center, which operates as a joint facility for the Army and the Air Force. Army officials explained that, prior to this joint effort, there were more than 12 contracts with nursing requirements between Brooke Army Medical Center and the Air Force's Wilford Hall Medical Center, both in San Antonio. The multiple contracts created competition between the two military departments' facilities for nursing staff. Because of the BRAC-related realignment of medical services in

[27]In 2012, DOD established working groups in response to the Military Health System governance decision to create a defense health agency. One working group was established to complete an assessment of the shared services to be used by this defense health agency. This working group is comprised of 12 subworking groups, one of which is focused on contracting. According to an Army official, as of February 2013, the contracting subworking group had not completed its assessment or reached any conclusions. For more information on Military Health System governance, see DOD, *Task Force on Military Health System Governance*, September 29, 2011, and GAO-12-911.

[28]Pub. L. No. 112-239, § 731.

San Antonio, the Army was able to consolidate the nursing requirements and use one multiple-award contract for registered nurses and one for licensed vocational nurses to provide nursing services at both facilities.[29] According to Army officials, these contracts are more successful than the previous contracts in placing the necessary number of nurses in the MTFs in San Antonio, and less administrative oversight is needed.

In the National Capital Region, the Army had multiple-award contracts for health care professionals that were awarded prior to the transfer of control to JTF CapMed. The Army then began to award contracts for JTF CapMed facilities in 2012.[30] These contracts are considered to be joint because these facilities are used by more than one military department as a result of the BRAC process. According to an Army analysis, these contracts resulted in a 14 percent savings over the previous set of contracts for health care professionals at the Walter Reed National Military Medical Center in Bethesda.

The Navy also used multiple-award contracts for health care professionals for MTFs in the National Capital Region that were awarded prior to the transfer of control to JTF CapMed at the end of fiscal year 2011. Other than the contracts that were in place for these MTFs before August 2011, the Navy stated that it did not have any additional contracts that were used by other military departments. The Air Force stated that it has not awarded any contracts with jointly developed requirements, but Air Force multiple-award contracts are open to use by other military departments to support joint MTFs.

While examples of joint contracting efforts in place during fiscal year 2011 were limited, additional contracts available to more than one military department have been awarded since then, or are planned.[31] For example, seven joint medical service contracting initiatives were planned by the Army, including a new contract for medical services in Europe that

[29]Licensed vocational nurses are entry-level nurses who provide basic health care.

[30]Through a memorandum of agreement in 2010, the Army Medical Command became the primary acquisition activity for the facilities in the National Capital Region.

[31]Also in 2009, the Army awarded regional multiple-award contracts for physicians, nurses, and ancillary providers. All military departments can place task orders against these multiple-award contracts, although it is unclear about the extent to which the Air Force and the Navy used them.

would be available to all three military departments. None of these has been awarded as of February 2013.

Intraservice Consolidation

The military departments have made efforts to consolidate some staffing requirements within their own MTFs using multiple-award contracts. Currently, multiple-award contracts in the Army and Navy are generally set up by U.S. geographical region and by provider type to meet the requirements of more than one facility. For example, in each geographical region, the Army and the Navy each have multiple-award contracts for nurses, and one in each region for doctors. In 2012, the Navy had 6 multiple-award contracts on the west coast and 5 on the east coast, including many types of health care professionals. The Navy routinely receives 25 to 40 proposals, and usually makes 3 to 6 awards to health care staffing companies. Navy officials told us that before multiple-award contract use was prevalent, buying activity was more fragmented. More individual contracts—for specific labor categories and locations—made the burden much greater in terms of administration and oversight. Officials explained that, at one point, the organization responsible for medical services acquisitions was funded on the basis of how many contracts were awarded, which incentivized inefficiency.

In contrast, the Air Force uses multiple-award contracts that are set up nationally to be used by all of its MTFs, and these contracts also include many types of health care professionals. The Army awarded national contracts for health care professionals in fiscal year 2003, but officials said this approach was unsuccessful because not enough companies were able to compete for those contracts and provide health care staffing services on a national scale. Market research and feedback from contractors indicated that regional multiple-award contracts would allow greater opportunities for more small businesses to compete. The Army subsequently put in place multiple-award contracts with regional requirements for particular categories of health care professionals, such as nurses. The Army found that this approach led to more successful outcomes.

Despite the use of multiple-award contracts, the potential for more consolidation among task orders remains. We identified several instances where many task orders were placed for the same type of provider in the same area or facility, such as 24 task orders in fiscal year 2011 for medical assistants, 16 separate task orders for Licensed Practical Nurses, 8 for clinical psychologists and 6 for family practitioners, all at the same MTF.

Almost All Contract Health Care Professionals Work in On-Base Military Treatment Facilities

Nearly all of the military departments' contract health care professionals—96 percent—worked in facilities located on military installations in fiscal year 2011. The costs associated with these contracted health care services provided at on-base facilities are not comparable to off-base facilities for a variety of reasons. For example, significant issues have been identified within the Military Health System cost accounting system that affect the calculation of unit costs. Further, based on available data and interviews with DOD officials, we determined that labor categories, labor costs, and full-time equivalent calculations all vary by military department, and in some cases by facility or contract. In addition, according to Navy officials, market-based salaries for the same type of provider can vary by geographic location.

Most Direct Care by Contract Health Care Professionals Is Provided at Facilities Located on Military Installations

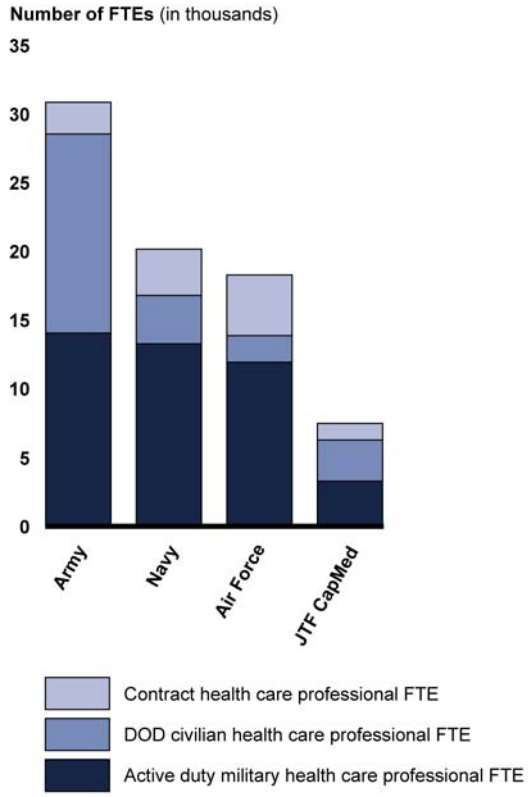
DOD reported information on 114 primary on-base MTFs in the United States with contracted health care professionals.[32] In addition, the military departments identified 8 off-base facilities with contracted health care professionals.[33] Collectively, the Army, Navy, Air Force, and JTF CapMed had 11,253 full-time equivalent (FTE) contract health care professionals within the United States in fiscal year 2011, 96 percent of whom provided care at on-base facilities.[34] Figure 5 shows the number of contract health care professionals, civilian health care professionals, and active duty military health care professionals in fiscal year 2011, by military department and JTF CapMed.

[32]For our reporting purposes, we refer to parent MTFs as primary MTFs. These primary facilities also often have subfacilities—smaller satellite facilities that report to the primary MTFs. The number of contracted health care professional FTEs working at on-base subfacilities is included in the total number of FTEs for each primary MTF.

[33]Off-base facilities reported to us are not physically located on a military installation, operate under the purview of an MTF commander, and have contract health care professionals who provide direct patient care.

[34]The definition of FTE employment is the total number of regular hours (i.e., not including overtime) worked by employees divided by the number of compensable hours applicable to each fiscal year. Each military department calculates FTEs differently. For the purposes of our review, we reported the number of FTEs for each military department that were provided to us by each military department and did not use them for comparative purposes. Counting the number of personnel would be misleading, as many health care professionals are contracted to work less than full time.

Figure 5: Number of Full-Time Equivalent Health Care Professionals by Military Department and the Joint Task Force National Capital Region Medical Command, Fiscal Year 2011



Source: GAO analysis of DOD data.

Notes: Each military department calculates FTEs differently. Numbers in the bar chart reflect an FTE count, not an actual personnel count. The Joint Task Force National Capital Region Medical Command manages MTFs within the National Capital Region.

Table 4 provides information on the number of contracted FTEs at both on-base and off-base facilities. For a complete list of the MTFs and contract health care professional FTEs reported to us by the military departments, see appendix III.[35]

[35]In 1995, DOD issued a policy memo stating that any contractor-owned, contractor-operated clinics should be converted to TRICARE government-managed outpatient clinics that function as extensions of the MTFs. Since the memo was issued, according to an Air Force official, the number of off-base facilities has decreased.

Table 4: Number and Percentage of DOD Contract Health Care Professionals at Off-Base Facilities in Fiscal Year 2011, by Military Department

Military department	Total number of contracted full-time equivalents (FTE)[a]	Obligations	Number of off-base facility contracted FTEs[a]	Percentage of contracted FTEs working at off-base clinics
Army	2303	$286,030,192	0	0.0
Navy	3368	292,825,958	128	3.9
Air Force	4415	453,674,285	12	0.3
JTF CapMed[b]	1167	105,112,968	274	23.4
Total	**11,253**	**$1,137,643,403**	**414**	**3.7**

Source: GAO analysis of DOD data.

[a]The number of FTEs shown for each military department is rounded to the nearest whole FTE.

[b]The Joint Task Force National Capital Region Medical Command (JTF CapMed) manages MTFs within the National Capital Region. JTF CapMed officials specified that the JTF CapMed facilities are managed as joint facilities and should be reported separately from the other military departments' data.

Specifically:

- The Army reported that all contract health care professionals worked in 28 primary on-base MTFs. The Army did not report any off-base facilities with contract health care professionals.[36]
- The Navy reported 21 on-base primary MTFs. Four percent of its contract health care professionals worked in one of four off-base clinics.
- The Air Force reported 63 on-base primary MTFs. Less than 1 percent of its contract health care professionals worked in one reported off-base clinic associated with the MTF at MacDill Air Force Base as well as one primary MTF, Buckley, which is located off-base.
- JTF CapMed reported two on-base primary MTFs—the Walter Reed National Military Medical Center, which combined Walter Reed Army Medical Center and Bethesda Naval Medical Center; and DeWitt Army Community Hospital, which became the Ft. Belvoir Community

[36]Although the Army has 15 off-base clinics, with four more scheduled to open in 2013, they are staffed by DOD employees and not by contract health care professionals. These clinics, called community-based medical homes, are Army-run primary care clinics located off-base in the communities where Army families live.

Hospital in 2011. Twenty-three percent of contract health care professionals in the National Capital Region worked in one of two off-base clinics, the Fairfax Health Center and the Dumfries Health Center.

Costs Associated with Contract Health Care Professionals at On-Base Facilities Are Not Comparable to Those at Off-Base Facilities

Based on available data and interviews with DOD officials, we determined that the costs associated with the provision of care by contract health care professionals at on-base facilities and off-base facilities were not directly comparable for a variety of reasons. First, DOD does not collect and maintain standardized data on health care professionals that would allow for comparisons of the cost of facilities across the military departments, or even within a military department from one facility to another. For example, labor categories are not standardized across DOD. Labor costs, including salary, benefits, overtime, and other costs vary by military department and by contract, and the definition of an FTE employee varies by military department. Second, DOD's Task Force report on the Future of Military Health Care concluded that there were significant issues with the Military Health System cost accounting that affect the correct calculation of unit costs.[37] For example, reported workload data have been characterized as unreliable. DOD and military department officials we spoke with confirmed this assessment during our review. Third, the financial and data systems used by MTFs are not set up to differentiate between the cost of care provided by contract health care professionals versus the cost of care provided by civilian and active duty health care professionals. Finally, market-based salaries for health care professionals vary by geographic location and by specialty. For example, the salary for a chiropractor in Washington, D.C. is significantly higher than the salary for a chiropractor in the Portsmouth, Virginia area. Therefore, comparing the costs associated with contract health care professionals at off-base facilities to any contract health care professionals at on-base facilities that were not working in the same geographic area would not result in an appropriate comparison.

[37]DOD, *Task Force Report on the Future of Military Health Care*, December 2007. The Medical Expense and Performance Reporting System is the standard cost accounting system for the Military Health System. It contains financial, personnel, and workload data from the services' treatment facilities worldwide. A May 1999 GAO report also identified major concerns with DOD's Medical Expense and Performance Reporting System, including inconsistent data collection and reporting. See GAO, *Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concerns*, GAO/HEHS-99-39 (Washington, D.C.: May 28, 1999).

DOD Has Agency-wide Training Requirements for Contracting Personnel, and Health Care Experience Varies

DOD medical services contracting personnel are subject to DOD-wide training requirements, and health care experience varies for these personnel. The military departments provide CORs, but usually not contracting officers, with specialized training in contracting for health care professionals in addition to DOD's requirements. The training provided to contracting officers is generally not targeted to any specific area of acquisition, including health care.

Contracting Officers Are Subject to DOD-wide Certification Requirements

Contracting officers are federal employees with the authority to bind the government by signing a contract. Contracting officers across DOD are subject to the Defense Acquisition Workforce Improvement Act (DAWIA) requirements, which specify mandatory acquisition training and experience standards for DOD's acquisition workforce.[38] DOD requires all contracting officers to meet the same DAWIA requirements, regardless of any specialization. The training offered by the Defense Acquisition University (DAU) provides a foundation for acquisition and career field knowledge, and is not targeted to specific jobs, including the award and administration of contracts for health care professionals.[39] In this regard, contracting officers responsible for awarding and administering contracts for health care professionals are no different than DOD contracting officers working in other areas.

In addition to DOD-wide requirements, contracting officers responsible for contracts for health care professionals generally have access to health care-specific acquisition expertise within their organizations, according to officials from the Army and Navy. For example:

- Contracting officers at Army's Health Care Acquisition Activity work with the Medical Services Portfolio Manager, who serves as a resource for both health care and acquisition expertise and assists in

[38]The Defense Acquisition Workforce Improvement Act, Pub. L. No. 101-510, § 1201-1211 (1990).

[39]DAWIA established the DAU as the primary provider of acquisition training for DOD and the military departments.

the development of performance work statements and source selection.

- Navy contracting officers gain knowledge on the job through collocation at the Navy Medical Logistics Command with experienced contracting officers and program analysts with health care specialties.

The Army and Navy medical commands both have contracting officers with primary responsibilities related to the award and administration of contracts for health care professionals. The Army contracting officers we spoke with at the San Antonio Military Medical Center each reported having worked in medical contracting for over 8 years, awarding hundreds of contracts for health care professionals. Similarly, a Navy official provided documents showing that most Navy contracting officers responsible for contracts for health care professionals each has at least 3 years of experience in medical contracting.

The Air Force relies on base contracting offices to support contracting for health care professionals at its 63 MTFs and, in contrast to both the Army and Navy, most Air Force contracting officers responsible for awarding and administering contracts for health care professionals are also responsible for the acquisition of non-medical products and services. As a result, according to Air Force officials we spoke with, Air Force acquisition professionals involved in medical services require additional training in the use of an approach often used in this area, personal services contracting, which is characterized by the employer-employee relationship it creates between the government and the contractor's personnel.[40] These contracts, expressly or as administered, make the contractor personnel appear to be, in effect, government employees.[41] Personal services contracts are generally prohibited; however, personal services contracts for professional medical services for DOD are authorized by law.[42]

Although all three services use personal services contracts to obtain health care professionals, additional training in this area is not necessary for the Army and Navy, according to a DAU official we spoke with, since

[40]FAR § 37.104.

[41]FAR § 2.101.

[42]10 U.S.C. § 1091.

these departments' contracting organizations have acquisition professionals who frequently work with personal services contracts. However, Air Force officials we spoke with reported that Air Force contracting personnel would benefit from increased attention to personal services contracting in the health care context, because, unlike most government contractors, health care professionals are subject to the direction and supervision of the government.[43]

Required and Supplemental Training Provided to Contracting Officer's Representatives

CORs are federal employees designated by the contracting officer to perform certain contract administration duties.[44] All CORs must meet training and experience requirements specified in DOD's Standard for Certification of COR for Service Acquisitions issued in March 2010. This standard defines DOD-wide minimum COR competencies, experience, and training for three types of COR requirements, according to the complexity of requirements and contract performance risk.[45] Prior to contract award, all CORs are required to take a basic 8-hour online training course, provided through DAU. In addition to DOD-wide requirements, contracting personnel we spoke with said CORs receive contract-specific training from the appointing contracting officer. CORs may also receive supplemental training provided by the military departments in medical services contracting. Table 5 describes the type of training provided to CORs by each military department.

[43]DOD Instruction 6025.5, *Personal Services Contracts (PSCs) for Health Care Providers (HCPs)* (Jan. 6, 1995).

[44]CORs are generally military or civilian DOD nonacquisition personnel that have acquisition-related responsibilities, such as helping to manage and oversee contracts by acting as the eyes and the ears of DOD's contracting officers and by serving as the liaisons between the contractor, the contracting officer, and the unit receiving support or services. CORs have no authority to make any commitments or changes that affect price, quality, quantity, delivery, or other terms and conditions of a contract.

[45]DOD Standard for Certification of Contracting Officer's Representatives (COR) for Service Acquisitions (Mar. 29, 2010).

Table 5: Training Provided to Contracting Officer's Representatives (COR) by Military Department

Military department	Training provided
Army	Army offers training on a quarterly basis for CORs on contracting fundamentals and the role of the COR at military treatment facilities. The training consists of a day and a half of instruction.
Navy	Navy provides CORs with a medical services training course prior to appointment to a contract for health care professionals, which consists of 2 days of classroom instruction in health care contracting.
Air Force	Air Force provides COR training in medical services contracting, the ordering of clinical services, acquisition funding, identifying requirements, oversight, as well as training on the computer-based system used to monitor the performance of health care professionals and staffing firms. Training is provided episodically in the field and in web-based sessions.

Source: GAO presentation of DOD information.

Contracting oversight begins when the MTF nominates and the contracting officer appoints CORs to monitor and report on contractor performance. Importantly, CORs may not direct the work of the contractor by making commitments or changes that affect price, quantity, quality, delivery, or other terms and conditions of the contract. Within DOD's Military Health System, CORs oversee the performance of contract health care professionals, including the review of contractor invoices and documenting and reporting on the performance of health care professionals to the contracting officer. The contract oversight model for DOD's Military Health System is different than typical DOD acquisitions, because the military departments reported regularly using personal services contracts when contracting for health care professionals who, as described above, are subject to the direction and supervision by the government. In contrast to typical DOD contracting oversight arrangements, supervision of contract health care professionals is typically accomplished by a government employee at the MTF.[46] In these instances, government supervisors, who are usually health care providers, work with the COR as they oversee and report on the performance of contract health care professionals.

The level of experience and type of responsibilities of CORs assigned to medical services contracts varies by MTF location. CORs we spoke with had responsibilities ranging from the oversight of only a few contract health care professionals to more than 100 professionals. Further, some

[46]DOD Instruction 6025.5 establishes that the performance of an individual health care professional under a personal services contract is subject to day-to-day supervision and control by health care facility personnel comparable to that exercised over active duty and civilian health care professionals engaged in comparable work.

CORs are full-time and dedicated solely to overseeing contracts for health care professionals. For selected locations, we observed the following:

- For the Army, a COR working at the San Antonio Military Medical Center with a professional background as a budget analyst reported that CORs in this location have backgrounds ranging from administrative professionals to physicians. This COR was responsible for other duties at the large facility in addition to overseeing the performance of 130 FTE health care professionals. The COR for personal services contracts at Fox Army Health Center, a health systems specialist and former Army medic, was responsible for additional duties as the Chief of Clinical Operations. The official had 12 years of experience as a COR on medical services contracts.

- For the Navy, personnel assigned as CORs at the Portsmouth Naval Medical Center and one of its branch clinics work on a full-time basis overseeing approximately 100 health care professionals each. This group's experience ranged from members with less than 1 year to those with over 20 years of experience. The COR at Navy's Saratoga Springs Branch Clinic was classified as a health systems specialist and had over 20 years of experience as a COR. This COR was located off-site and was responsible for other duties in addition to overseeing approximately 30 task orders for health care professionals.

- For Air Force, the service contract manager at Wilford Hall Ambulatory Surgical Clinic is the primary COR and government supervisors are alternate CORs.[47] However, this is an arrangement that is unique to that facility, according to Air Force officials. The COR for personal services contracts at Andersen Air Force Base reported having worked in this capacity for about a year and a half and was responsible for other duties related to medical logistics. Prior to assignment as a COR at Andersen Air Force Base, this official had over 4 years of experience in contract services at a large MTF.

[47]The Air Force utilizes full-time service contract managers at each of its MTFs who, by Air Force instruction, are required to be appointed as the primary COR for all locally administered contracts. These CORs are the focal point for all contracting matters within the MTF, while the government supervisors provide technical expertise and oversight, reported in accordance with the contract terms and conditions.

The Military Departments' Existing Policies and Procedures Generally Address Legislated Quality Standards, but DOD Did Not Require Consistency

Section 732 of the NDAA for FY 2007 directed the Secretary of Defense to require consistent quality standards for contract health care professionals and the staffing companies that provide them across all of the military departments' MTFs. According to DOD officials, DOD did not require consistent quality standards or take any additional actions in response to this legislation—such as by establishing a specific policy or guidance—because officials believed the military departments were already applying these standards as part of their contracting processes. We found that each of the departments had policies or procedures in place that generally address most of the NDAA for FY 2007 quality standards.

DOD and the Military Departments Already Had Policies for the Credentialing and Privileging of Health Care Professionals and Are Taking Steps to Ensure Consistency

The NDAA for FY 2007 requires consistent credentialing requirements among MTFs. Credentialing is the process of inspecting and authenticating the documentation for appropriate education, training, licensure, and experience for health care professionals. Privileging is the corresponding process that defines the scope and limits of practice for a health care professional based on their relevant training and experience, current competence, peer recommendations, and the capabilities of the facility where the health care professional is practicing.[48] The Assistant Secretary of Defense for Health Affairs is responsible for developing and overseeing DOD's credentialing and privileging requirements for health care professionals to ensure consistent application across the Military Health System.[49] To implement DOD's requirements, the military departments' surgeons general—who are delegated responsibility by the secretaries of their respective departments—establish specific credentialing and privileging requirements, which their MTFs are required to follow.

[48]While the NDAA for FY 2007 only required consistent credentialing requirements, our analysis examined the military departments' policies and procedures for both credentialing and privileging, which together help ensure that health care professionals who work in MTFs have the appropriate credentials and clinical competence.

[49]DOD Instruction 6025.13 and the associated DOD Regulation 6025.13-R—which contain procedures for the credentialing and privileging of health care professionals—require the Assistant Secretary of Defense for Health Affairs to ensure their consistent implementation across the Military Health System. DOD Regulation 6025.13-R is mandatory for use by all DOD components.

In this review, we found that DOD and the military departments already had policies and procedures in place for the credentialing and privileging of health care professionals; however, these requirements are not yet consistent across the military departments.[50] We previously reported in December 2011 that the military departments had established requirements that were in some cases inconsistent with DOD's requirements and each other's.[51] In response, DOD and military department officials reported taking steps to standardize the credentialing and privileging processes across DOD. For example, the Navy took steps to align its policy with DOD's by changing its requirement for primary source verification to apply to all provider licenses ever held instead of just those licenses held in the past 10 years.[52] Additionally, DOD and VA formed a workgroup in July 2012—which also included officials from the Army, Navy, Air Force, and JTF CapMed—in order to standardize the credentialing and privileging processes across the military departments, and eventually with VA, so that health care professionals could more easily move between DOD and VA facilities. As part of this effort, the workgroup was tasked with exploring the possibility of developing a joint credentialing software system for use by both DOD and VA. A DOD official told us that the workgroup expects to issue recommendations by June 2013.

Military Departments Have Policies or Procedures That Generally Address the Standards for Staffing Companies

The NDAA for FY 2007 also requires consistent quality standards for the staffing companies that provide contract health care professionals to the MTFs, including, at a minimum, the Joint Commission's Health Care Staffing Services certification standards.[53] The 2011 version of the Health Care Staffing Services certification standards includes 23 standards that cover four topic areas: (1) leadership, (2) human resources management,

[50]Each military department's policies for credentialing and privileging apply to all health care professionals, including contract professionals.

[51]See GAO, *DOD Health Care: Actions Needed to Help Ensure Full Compliance and Complete Documentation for Physician Credentialing and Privileging*, GAO-12-31 (Washington, D.C.: Dec. 15, 2011).

[52]One of the reasons for primary source verification would be to determine whether disciplinary action had been taken against a physician's license.

[53]The Joint Commission is an independent, not-for-profit organization that accredits and certifies more than 20,000 health care organizations and programs in the United States.

(3) information management, and (4) performance measurement and improvement.[54] (See appendix IV for a list of these standards.)

We found that because DOD did not require the military departments to use consistent quality standards for staffing companies as outlined in the NDAA for FY 2007, the military departments did not have policies or procedures in place for each of the Joint Commission's Health Care Staffing Services certification standards.[55] However, each of them was able to provide examples of regulations, policies, or military department-wide standardized contracting language that they thought addressed many of these standards. The Air Force was able to provide similar documentation for its centrally administered health care professional contracts. The Air Force also was able to provide examples of regulations and policies for its other health care professional contracts, which are awarded and managed at the individual MTF level, but it could not provide standardized language for these contracts.

We determined that, in most cases, the documentation provided by each of the military departments generally addressed the individual Joint Commission standards for staffing companies that provide health care professionals. For example:

- For the Joint Commission requirement that the staffing company have a code of business ethics, each of the military departments provided citations to federal regulations or standardized contract clauses that required the staffing company to have an ethics code.

In some of these cases, the military departments addressed the individual Joint Commission standards by providing policies or standardized contract language that required the military departments to perform the tasks themselves instead of expecting them to be addressed by the staffing company. For example:

[54]Although the Joint Commission has a 2012 version of the Health Care Staffing Services certification standards, we used the 2011 version to be consistent with other data timeframes used in the report. There are no substantial differences between the 2011 and 2012 versions of the standards.

[55]Officials we spoke with from the Army, Navy, and JTF CapMed were not familiar with the Joint Commission's Health Care Staffing Services certification standards prior to our review.

- For the Joint Commission requirement that the staffing company provide orientation to clinical staff, each of the military departments cited standardized contract clauses that would require contract health care professionals to participate in orientation and initial job training provided by the MTF.

However, the documentation provided by the military departments did not always appear to address certain Joint Commission standards. For example:

- For the Joint Commission requirement that the staffing company clearly define its leadership roles,[56] one of the military departments cited standardized contract language that required the staffing company to provide a point of contact, but did not address company leadership roles.

In addition to the Joint Commission standards for staffing companies, the NDAA for FY 2007 also requires additional standards covering financial stability, medical management, continuity of operations, training, employee retention, access to contractor data, and fraud prevention. We found that each of the military departments provided documentation that generally addressed the additional standards for staffing companies listed in the NDAA for FY 2007. For example, each of the military departments provided citations to federal regulations that addressed fraud prevention for the staffing companies.

Conclusions

DOD has undertaken numerous studies concerning the governance of the Military Health System. Performed by both internal and external boards, commissions, task forces, and other entities, a number of these studies recommended dramatic changes in the organizational structure of the Military Health System, in part to address the fragmented approach that the military departments take to contracting for professional medical services. While the military departments generally agreed with the need for improvements to their respective requirements determination processes, fragmentation in requirements and contracting arrangements

[56]For example, showing that the leaders involved in the staffing company's development and oversight have the knowledge or experience to provide the organization access to resources with appropriate expertise, and whether the leaders set goals, develop plans, and manage the company's performance measurement and improvement activities.

persist because DOD has introduced change in its management and oversight of the Military Health System in an incremental and limited manner.

In the absence of a DOD-wide approach for the acquisition of medical services, each military department continues to take a fragmented approach to contracting for medical professionals without considering the collective needs of the Military Health System. However, DOD is in the process of revising the governance structure of the Military Health System to centralize certain functions, such as acquisitions, that are fragmented among the military departments. Consequently, now is a particularly opportune time to revisit the need for a DOD-wide strategic sourcing strategy with both near-term and long-term dimensions, including reliable and detailed agency-wide data. Without such a strategy, the Military Health System may be missing opportunities for acquiring professional medical services in the most cost effective manner.

Recommendation for Executive Action

To achieve additional cost savings and efficiencies through increased use of strategic sourcing, we are recommending that the Secretary of Defense develop and implement a DOD-wide strategy to contract for health care professionals. The strategy should identify specific responsible organizations and timeframes, and should consist of both near-term and long-term components:

- In the near term, and to enable DOD to assess the efficacy and impact of such a strategy, DOD should identify a category of health care professionals or a multi-service market to pilot an approach to consolidating health care staffing requirements.
- Over the longer term, such a strategy should include an analysis of medical services spending based on reliable and detailed agency-wide data, and should enable DOD to identify opportunities to consolidate requirements and reduce costs.

Agency Comments

We provided a draft of this report to DOD for comment. In its written comments, reproduced in appendix V, DOD concurred with our recommendation. The department also agreed that it is at an opportune time to revisit a Military Health System strategic sourcing strategy due to the organizational transformation that is occurring in the stand-up of the new Defense Health Agency. DOD stated that a Shared Services Contracting subworking group will include this report and its

recommendations in their comprehensive review of contracting strategies, governance, and processes. DOD anticipates that the subworking group will present their final recommendations to senior leadership by August 2013. DOD also provided technical comments that were incorporated, as appropriate.

We are sending copies of this report to the appropriate congressional committees and the Secretary of Defense. In addition, the report is available at no charge on GAO's website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-4841 or woodsw@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made key contributions to this report are listed in appendix VI.

William T. Woods
Director
Acquisition and Sourcing Management

Appendix I: Scope and Methodology

To determine what contracting practices are used by the military departments to contract for medical services as well as what is known about the cost effectiveness of these practices, we analyzed fiscal year 2011 data obtained from the Federal Procurement Data System-Next Generation on medical service contracts to determine the extent to which the military departments used particular contracting practices as well as the types and amount of medical services that were purchased.[1] We obtained data on all contracts and task orders that were coded as medical services and were active in fiscal year 2011 from the Federal Procurement Data System-Next Generation, including information on obligation value, contract payment type, a general description of the type of service, and the extent of competition. To assess the reliability of the data we looked for missing values and obvious errors and found the data were sufficiently reliable for the purposes of our analysis and findings. We interviewed officials from Army's Health Care Acquisition Activity, the Navy Medical Logistics Command, the Air Force Medical Service group, the Joint National Capital Region Medical Command (JTF CapMed), and TRICARE Management Activity (TMA). Additionally, we obtained and analyzed information from these officials on the contracting arrangements the departments used and any cost effectiveness studies that had been completed. We also reviewed GAO reports on costs and outcomes associated with different contracting approaches.

To determine the extent to which the military departments have consolidated health care staffing requirements and to what effect, we obtained data from each of the military departments as well as JTF CapMed on the number and dollar value of department-identified contracts with consolidated staffing requirements, including joint contracts, contracts for medical services at joint military treatment facilities (MTF), and multiple-award indefinite-delivery, indefinite-quantity contracts. We relied on this data to present the percentage and total dollar value of multiple-award indefinite-delivery, indefinite-quantity contracts awarded by the military departments that were active in fiscal year 2011. To assess the reliability of these data we interviewed officials from the military departments on how they ensured the data were accurate and reliable, and tested the data for any missing values or obvious errors and then followed up with officials to obtain corrected data.

[1]We considered a contact as active if an obligation or deobligation of funds was made on that contract in fiscal year 2011.

We found the data were sufficiently reliable for the purposes of our analysis and findings. We spoke with officials from the military departments' contracting organizations to determine if cost savings could be demonstrated based on the use of multiple-award contracts. We also reviewed past reports by the Department of Defense (DOD), GAO, and others.

To determine the percentage of contract health care professionals who work at on-base MTFs versus off-base facilities, we requested that the three military departments, JTF CapMed, and TMA provide us data on the type, number of, and total obligations in fiscal year 2011 associated with contract health care professionals providing direct patient care at all MTFs and associated off-base clinics within the United States and her territories in fiscal year 2011.[2] For the purposes of our review, we collected data on parent MTFs and those off-base facilities which were under the purview of the MTF commander, were physically located outside the military installation, received some direct care dollars, and employed contract health care professionals. We defined a health care professional as an individual providing primary, specialty, or ancillary services at an MTF or associated off-base clinic who has received specialized training or education in a health related field. We excluded from our scope MTFs located outside of the United States; and we also excluded contracts for research and development-related services, dental and veterinary professions, as well as administrative, janitorial, food, or housekeeping services. To assess the accuracy and completeness of the reported data, we interviewed officials from the military departments on how they ensured the data were accurate and reliable. We also tested the data for any missing values or obvious errors and then followed up with officials to get corrected data. Based on our analyses and discussions with military department officials, we determined that caution should be exercised when using their data to draw conclusions about the actual number of contracted health care professionals in MTFs for any given time period. However, because we are presenting the reported data at a level where they describe a high level overview of the number of contract health care professionals providing care at MTFs during our period of review, we believe the data are sufficiently reliable for the purposes of our review.

[2]The Air Force reported one MTF located in Guam, a U.S. territory.

To determine the extent to which costs associated with contract health care professionals at on-base and off-base facilities could be compared, we met with contracting officials from the military departments, TMA, and personnel at select MTFs to discuss the data we had received and the proposed cost comparison.[3] Based on the data received from the military departments and these discussions, we concluded that DOD had not conducted a similar cost comparison of on-base and off-base facilities, and that the military department-reported data could not be used to compare costs associated with on- and off-base facilities since the number of off-base facilities was limited and costs associated with the different facilities could not be appropriately compared for a number of reasons, as indicated in this report. We were able to determine that the data were sufficiently reliable to present information on the number of and aggregate costs associated with contract health care professionals, but not for the purposes of a comparison of costs associated with on-base versus off-base facilities.

To determine the training requirements and experience of personnel responsible for awarding and administering contracts for health care professionals, we interviewed officials from the military departments' contracting organizations and collected supporting documentation on DOD-wide and military department-specific policy and requirements. For the purposes of this review, we limited the scope of our analysis to contracting officers and contracting officer's representatives (COR). We obtained additional descriptive information on the specific health care and acquisition training and experience of contracting personnel at selected medical facilities from each military department with small and large numbers of contract health care professionals on staff.[4] We selected these facilities based on the number of full-time equivalent (FTE) contract health care professionals the military departments reported to be working at each MTF in fiscal year 2011. We also visited selected MTFs, including three of the seven off-base clinics identified by the military departments,

[3]We interviewed officials from Ft. Belvoir Community Hospital, Walter Reed National Military Medical Center, Fairfax TRICARE Clinic, Dumfries TRICARE Clinic, San Antonio Military Medical Center, Portsmouth Naval Medical Center, and the TRICARE Prime Clinic Virginia Beach.

[4]We held meetings and/or received written responses to questions from officials at the San Antonio Military Medical Center, Fox Army Health Center, Portsmouth Naval Medical Center, Saratoga Springs Naval Health Clinic, Wilford Hall Ambulatory Surgical Center, and Andersen Air Force Base Clinic.

and interviewed officials with knowledge of the training and experience of contracting officers and CORs. Finally, we interviewed an official from the Defense Acquisition University regarding training in personal services contracts. We did not evaluate training records of contracting officers or CORs for sufficiency.

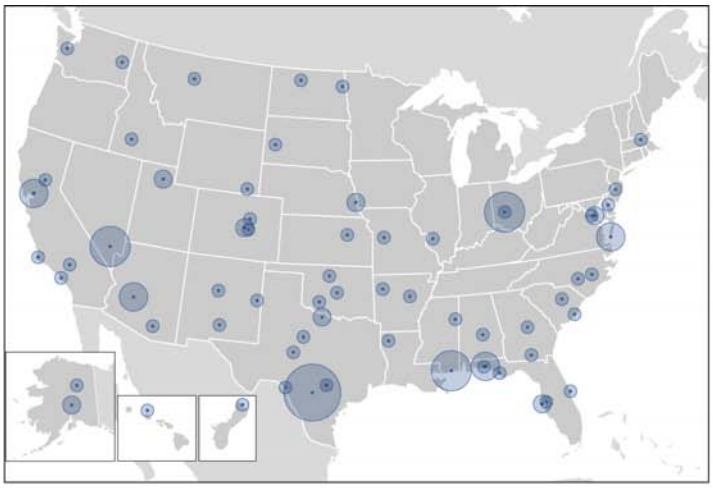
To determine the extent to which the military departments have policies or procedures that generally address legislated quality standards for contract health care professionals and the staffing companies that provide these professionals, we obtained documentation such as federal regulations, DOD and military department-level policies and procedures, and military department-wide standardized contracting language, as provided to us by each of the military departments and JTF CapMed. We reviewed this documentation to assess whether it generally addressed the legislated quality standards in the National Defense Authorization Act for Fiscal Year 2007, including the 2011 version of the Joint Commission's Health Care Staffing Services standards. We also interviewed officials from DOD, each of the military departments, and JTF CapMed to better understand how, if at all, the legislated quality standards were incorporated into their policies and procedures for contracting for health care professionals. Our analysis focused on whether the policies and procedures generally addressed the legislated standards; we did not assess the military departments' compliance with these standards.

To gain insight applicable to all objectives, we selected a nongeneralizable sample of MTFs based on the military department, the location, and the number of contract health care professionals at each facility. We met with officials from Ft. Belvoir Community Hospital, Walter Reed National Military Medical Center, Fairfax TRICARE Clinic, Dumfries TRICARE Clinic, San Antonio Military Medical Center, Portsmouth Naval Medical Center, and the TRICARE Prime Clinic Virginia Beach. We held meetings or received written responses to questions from officials at Fox Army Health Center, Saratoga Springs Naval Health Clinic, Wilford Hall Ambulatory Surgical Center, and Andersen Air Force Base Clinic. While the sample allowed us to learn about many important aspects of, and variations in, contracting for health care professionals in military treatment facilities, it was designed to provide anecdotal information, not findings that would be representative of all MTFs worldwide. See appendix III for complete list of MTFs.

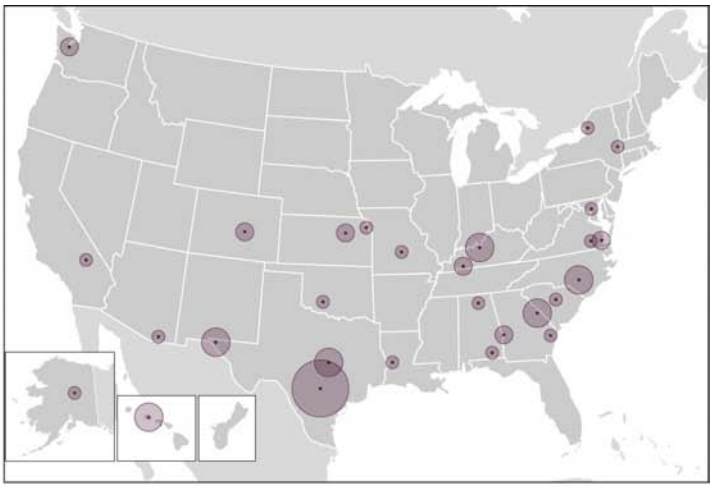
We conducted this performance audit from July 2012 to May 2013 in accordance with generally accepted government auditing standards.

Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

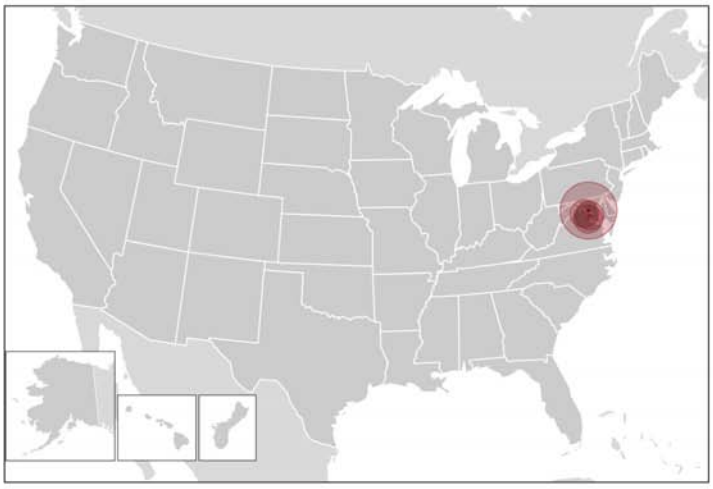
Appendix II: Interactive Graphic Information for the Location of On-Base MTFs and the Number of FTEs at Each Location



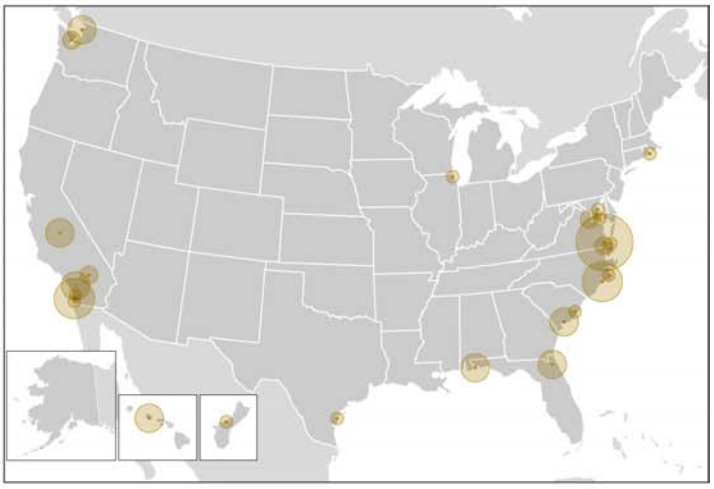
Air Force FTEs



Army FTEs



JTF CapMed FTEs



Navy FTEs

Source: GAO analysis of DOD data; Map Resources (map).

Appendix III: Military Treatment Facilities and Total Contracted Full-Time Equivalents (FTE) by Military Department

Military department	Facility name	FTEs, fiscal year 2011
Army	Brooke Army Medical Center	574
	Carl R. Darnall Army Medical Center	235
	Tripler Army Medical Center	167
	William Beaumont Army Medical Center	160
	Womack Army Medical Center	159
	Ireland Army Community Hospital	122
	Dwight D. Eisenhower Army Medical Center	110
	Evans Army Community Hospital	84
	Irwin Army Community Hospital	80
	Martin Army Community Hospital	72
	Madigan Army Medical Center	71
	McDonald Army Health Center	60
	General Leonard Wood Army Community Hospital	50
	Keller Army Community Hospital	49
	Reynolds Army Community Hospital	44
	Bayne Jones Army Community Hospital	40
	Blanchfield Army Community Hospital	37
	Guthrie Army Health Center	37
	Kimbrough Ambulatory Care Center	30
	Winn Army Community Hospital	29
	Bassett Army Community Hospital	20
	Kenner Army Health Clinic	18
	Munson Army Health Center	18
	Moncrief Army Community Hospital	13
	Weed Army Community Hospital	12
	Bliss Army Health Center	8
	Lyster Army Health Clinic	1
	Fox Army Health Center	1
Navy	Naval Medical Center Portsmouth	939
	Naval Hospital Camp Lejeune	406
	Naval Medical Center San Diego	360
	Naval Hospital Pensacola	191
	Naval Hospital Camp Pendleton	178
	Naval Hospital Jacksonville	176
	Naval Hospital Oak Harbor	135
	Naval Hospital Lemoore	135

Military department	Facility name	FTEs, fiscal year 2011
	Naval Health Clinic Hawaii	130
	Naval Hospital Beaufort	102
	Naval Health Clinic Quantico	96
	Naval Hospital Bremerton	69
	Naval Hospital Twenty Nine Palms	56
	TRICARE Prime Clinic Chesapeake (off-base facility associated with Naval Medical Center Portsmouth)	**53**
	Naval Health Clinic Annapolis	49
	Naval Health Clinic Cherry Point	47
	Naval Health Clinic New England	46
	Naval Health Clinic Great Lakes	36
	Naval Hospital Corpus Christi	33
	TRICARE Prime Clinic Virginia Beach (off-base facility associated with Naval Medical Center Portsmouth)	**30**
	Naval Health Clinic Patuxent River	28
	TRICARE Outpatient Clinic Chula Vista (off-base facility associated with Naval Medical Center San Diego)	**27**
	Naval Health Clinic Charleston	22
	TRICARE Outpatient Clinic Clairemont (off-base facility associated with Naval Medical Center San Diego)	**18**
	Naval Hospital Guam	5
Air Force	Lackland Air Force Base	764
	Nellis Air Force Base	498
	Wright Patterson Air Force Base	384
	Keesler Air Force Base	336
	Travis Air Force Base	235
	Eglin Air Force Base	231
	Langley Air Force Base	184
	Luke Air Force Base	113
	Joint Base Elmendorf-Richardson	97
	Joint Base Andrews	92
	MacDill Air Force Base	77
	Offutt Air Force Base	78
	Colorado Springs	71
	Sheppard Air Force Base	52
	Hill Air Force Base	52
	Randolph Air Force Base	49

Military department	Facility name	FTEs, fiscal year 2011
	Davis-Monthan Air Force Base	49
	Maxwell Air Force Base	49
	Hurlburt Field	47
	Robins Air Force Base	47
	Patrick Air Force Base	45
	Holloman Air Force Base	45
	Scott Air Force Base	44
	Barksdale Air Force Base	43
	Joint Base McGuire-Dix-Lakehurst	39
	Mountain Home Air Force Base	39
	Tinker Air Force Base	38
	Peterson Air Force Base	33
	Little Rock Air Force Base	32
	Seymour Johnson Air Force Base	30
	Tyndall Air Force Base	29
	Goodfellow Air Force Base	29
	Ellsworth Air Force Base	28
	Moody Air Force Base	26
	Shaw Air Force Base	25
	Kirtland Air Force Base	25
	U.S. Air Force School of Aerospace Medicine	25
	Minot Air Force Base	25
	Beale Air Force Base	25
	Dover Air Force Base	23
	Joint Base Charleston	22
	McConnell Air Force Base	21
	Vandenberg Air Force Base	20
	Dyess Air Force Base	18
	Edwards Air Force Base	18
	Joint Base Anacostia Bolling	16
	Whiteman Air Force Base	15
	Fairchild Air Force Base	14
	Joint Base Pearl Harbor-Hickam	14
	Los Angeles Air Force Base	13
	Malmstrom Air Force Base	12
	Francis E. Warren Air Force Base	11

Military department	Facility name	FTEs, fiscal year 2011
	Grand Forks Air Force Base	11
	Vance Air Force Base	10
	Cannon Air Force Base	9
	Buckley Air Force Base (off-base primary military treatment facility)	**9**
	Columbus Air Force Base	8
	Eielson Air Force Base	7
	Pope Field	5
	Hanscom Air Force Base	5
	Altus Air Force Base	4
	Laughlin Air Force Base	4
	McChord Air Force Base	3
	Andersen Air Force Base	3
	Brandon Clinic (off-base facility associated with MacDill Air Force Base)	**3**
Joint Task Force National Capital Regional Medical Command (JTF CapMed)	Walter Reed National Military Medical Center (Previously the Walter Reed Army Medical Center and the National Naval Medical Center)	775
	Dumfries TRICARE clinic (off-base clinic associated with Fort Belvoir Community Hospital, previously Woodbridge Family Health Center)	**165**
	Fort Belvoir Community Hospital (Previously Dewitt Army Community Hospital)	119
	Fairfax TRICARE clinic (off-base clinic associated with Fort Belvoir Community Hospital)	**109**

Source: GAO analysis of DOD data.

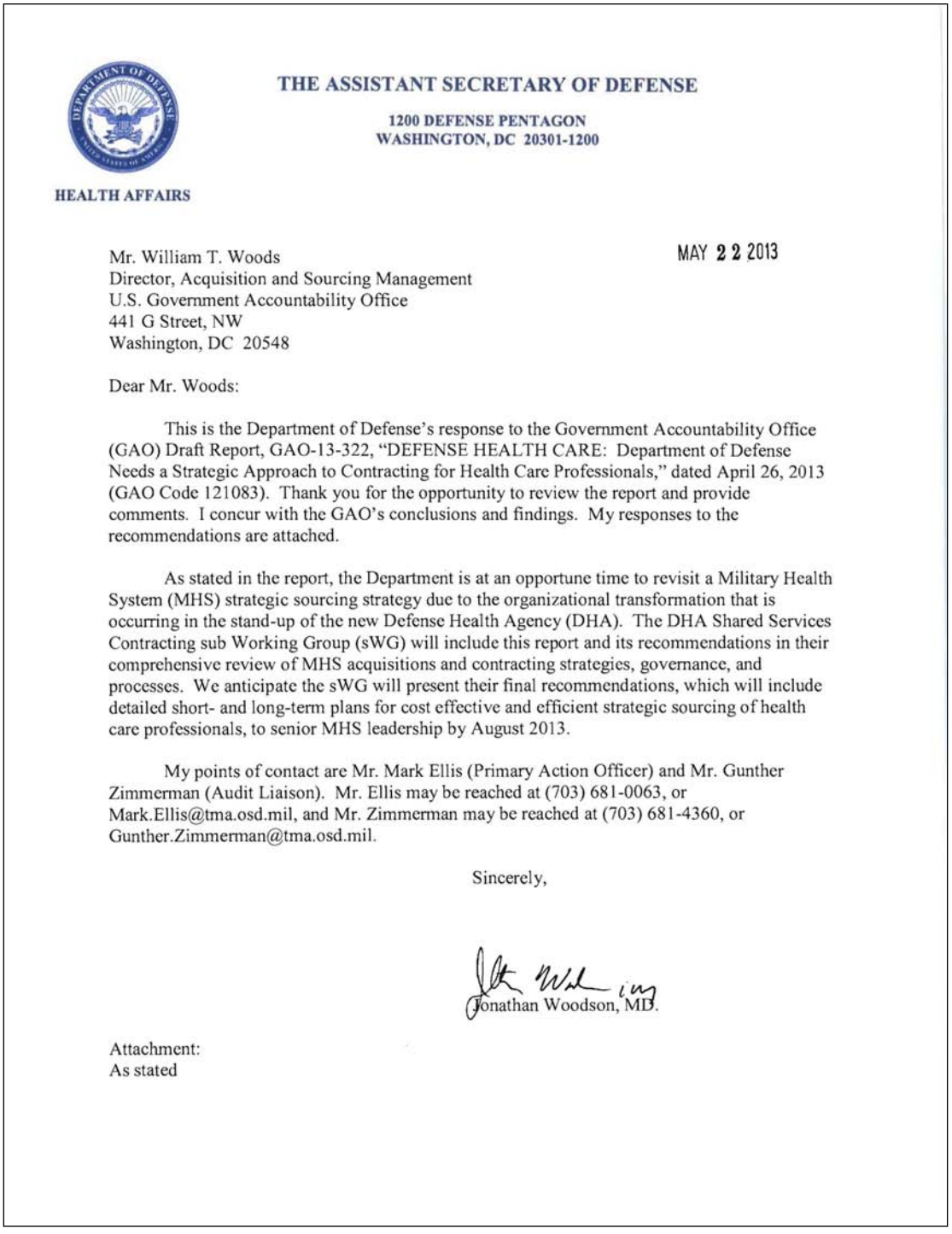
Note: off-base facilities are indicated in bold font.

Appendix IV: The Joint Commission's Health Care Staffing Services Standards, 2011

Leadership
1. The health care staffing services (HCSS) firm clearly defines its leadership roles.
2. The HCSS firm has a code of business ethics.
3. The HCSS firm addresses existing or potential conflicts of interest related to its internal and external relationships.
4. The HCSS firm complies with applicable laws and regulations.
5. The services contracted for by the HCSS firm are provided to customers.
6. The HCSS firm is accessible to customers and staff.
7. The HCSS firm addresses the resolution of complaints from customers and staff.
8. The HCSS firm identifies and takes steps to reduce safety risks.
9. The HCSS firm addresses emergency management.
Human Resources Management
1. The HCSS firm confirms that a person's qualifications are consistent with his or her assignment(s).
2. As part of the hiring process, the HCSS firm determines that a person's qualifications and competencies are consistent with his or her job responsibilities.
3. The HCSS firm provides orientation to clinical staff regarding initial job training and information.
4. The HCSS firm assesses and reassesses the competence of clinical staff and clinical staff supervisors.
5. The HCSS firm encourages the improvement of clinical staff competence through ongoing educational activities.
6. The HCSS firm evaluates the performance of clinical staff.
Information Management
1. Information management processes meet internal and external information needs.
2. The HCSS firm maintains health information and personnel records for clinical staff.
3. The HCSS firm preserves the confidentiality and security of information about clinical staff and customers.
4. The HCSS firm has a process for maintaining continuity of information.
Performance Measurement and Improvement
1. The HCSS firm plans an organized, comprehensive approach to performance improvement.
2. The HCSS firm maintains the quality and integrity of its data.
3. The HCSS firm collects data to evaluate processes and outcomes.
4. The HCSS firm analyzes its data.

Source: The Joint Commission's Health Care Staffing Services Certification Manual, 2011.

Appendix V: Comments from the Department of Defense



THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

MAY 22 2013

Mr. William T. Woods
Director, Acquisition and Sourcing Management
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Woods:

This is the Department of Defense's response to the Government Accountability Office (GAO) Draft Report, GAO-13-322, "DEFENSE HEALTH CARE: Department of Defense Needs a Strategic Approach to Contracting for Health Care Professionals," dated April 26, 2013 (GAO Code 121083). Thank you for the opportunity to review the report and provide comments. I concur with the GAO's conclusions and findings. My responses to the recommendations are attached.

As stated in the report, the Department is at an opportune time to revisit a Military Health System (MHS) strategic sourcing strategy due to the organizational transformation that is occurring in the stand-up of the new Defense Health Agency (DHA). The DHA Shared Services Contracting sub Working Group (sWG) will include this report and its recommendations in their comprehensive review of MHS acquisitions and contracting strategies, governance, and processes. We anticipate the sWG will present their final recommendations, which will include detailed short- and long-term plans for cost effective and efficient strategic sourcing of health care professionals, to senior MHS leadership by August 2013.

My points of contact are Mr. Mark Ellis (Primary Action Officer) and Mr. Gunther Zimmerman (Audit Liaison). Mr. Ellis may be reached at (703) 681-0063, or Mark.Ellis@tma.osd.mil, and Mr. Zimmerman may be reached at (703) 681-4360, or Gunther.Zimmerman@tma.osd.mil.

Sincerely,

Jonathan Woodson, MD.

Attachment:
As stated

GAO DRAFT REPORT DATED APRIL 26, 2013
GAO-13-322 (GAO CODE 121083)

"DEFENSE HEALTH CARE: DEPARTMENT OF DEFENSE NEEDS A STRATEGIC APPROACH TO CONTRACTING FOR HEALTH CARE PROFESSIONALS"

DEPARTMENT OF DEFENSE COMMENTS TO THE GAO RECOMMENDATIONS

To achieve additional cost savings and efficiencies through increased use of strategic sourcing, the GAO recommends that the Secretary of Defense develop and implement a Department of Defense (DoD)-wide strategy to contract for health care professionals. The strategy should identify specific responsible organizations and timeframes and should consist of both near-term and long-term components:

RECOMMENDATION 1: In the near term, and to enable DoD to assess the efficacy and impact of such a strategy, DoD should identify a category of health care professionals or a multi-service market to pilot an approach to consolidating health care staffing requirements.

DoD RESPONSE: Concur. The Defense Health Agency (DHA) Shared Services Contracting sub Working Group (sWG) will incorporate this approach into its short-term contracting strategy.

RECOMMENDATION 2: Over the longer term, such a strategy should include an analysis of medical services spending based on reliable and detailed agency-wide data and should enable DoD to identify opportunities to consolidate requirements and reduce costs.

DoD RESPONSE: Concur. The DHA Shared Services Contracting sWG will complete such an analysis and make appropriate recommendations to the MHS senior leadership.

2

Appendix VI: GAO Contact and Staff Acknowledgments

GAO Contact

William T. Woods, woodsw@gao.gov, (202) 512-4841

Staff Acknowledgments

In addition to the contact named above, Debra A. Draper (Director); Bonnie Anderson (Assistant Director); LaTonya Miller (Assistant Director); Peter Anderson; Lori Atkinson; Jacob Leon Beier; E. Brandon Booth; Richard Burkard; Virginia Chanley; Gayle Fischer; Linda Galib; Julia Kennon; Victoria Klepacz; Heather B. Miller; Jeffrey Mayhew; Kenneth Patton; Carol D. Petersen; and Roxanna Sun made key contributions to this report.